MMC 20/20

CONSULTANTS ● SYSTEMS

RADV Audits: Protecting Yourself from a Bad Review
MA Strategic Business Symposium
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Agenda

- RADV Audits-Background
- RADV Audits-The Significance
- MMC 20/20 Approach to RADV Audits
- Chart Review/Submission
- Medical Record Review Process
- New Appeals Process
- Defending Against Adverse Results/Extrapolation
- Mock Audits

RADV Audits - Background

- Created to identify coding gaps between FFS providers and MA plans
- Occurs annually – 2006 data was audited in early 2009. RADVs for 2007 data should occur in late 2009/early 2010
- Plans are selected based on
  - Targeted: higher risk score growth than FFS
  - Targeted: performed poorly on previous audits
  - Random: equal opportunity of being selected
- Double penalty for bad audit—impact of bad audit and higher probability of being selected again
- RADV detail involves approx. 200 members with at least one HCC or RxHCC accepted on a RAPS in the data collection period

RADV Audits - Background

- Plans have limited time (12 weeks) after receiving member detail to complete RADV (three stages—10/29/09, 11/19/09 and 12/10/09 with due dates of 1/28/10, 2/18/10 and 3/11/10 respectively)
- CMS will allow the use of CMS-generated attestations to mitigate signature and credential issues on outpatient/physician medical records
- A revised documentation dispute and appeals process will be used
- CMS has also verbally confirmed that they will not allow physicians to attest to diagnoses that are not documented in the records
- RADV audit process is in addition to 3.41% coding intensity adjustment that CMS is initiating in 2010

RADV Audits – The Significance

- CMS plans to extrapolate results of RADV audits:

  Section F. CMS Audits

  In CY 2007, CMS' payments to MA plans were 100 percent risk-adjusted for the first time because the transition from demographic-only to risk-adjusted payments was completed. Given this milestone, CMS has determined that our Risk Adjustment Data Validation, starting with CY 2007 payments, will be conducted using a sampling frame that generates statistically valid plan-level payment error estimates for those plans selected for review.

  CMS will audit a subset of MA plans each year. The audit will include randomly-selected plans and targeted plans. Targeted plans will be selected based on how their risk score growth compared to FFS.

  Findings from our validation studies from CY 2007 onward may inform CMS why plan average risk scores did or did not grow rapidly. This analysis will allow us to further refine our MA coding intensity adjustment. In addition, because we will have statistically-valid plan-level error estimates, we will make plan-level payment adjustments rather than adjustments to payments for specific beneficiaries whose risk scores were not supported by the medical record reviews, as we have done previously.

- The impact of extrapolation
  - An average HCC is worth approximately $2,500
  - If 200 members are sampled for a 100,000 effected member plan (with an average of 2 HCCs per member), each missing HCC extrapolates to an impact of $2.5 million annually
  - If the error rate is 10%, the extrapolated annual impact would be $100 million

MMC 20/20 Approach to RADV Audits

- Move quickly…
- Identify all RADV audit team members and their roles and responsibilities
- Establish a well defined project plan and timeline with applicable reporting
- Customize approach for working with medical groups, external providers and hospitals
- Identify and document why the diagnosis supporting the HCC was submitted (all providers or other sources that triggered the RAPS submission)
- Use claims and encounters to identify all possible chart locations
  - Start with all claims and encounters for a sampled member
  - Eliminate providers that do not qualify for HCC submission
  - Identify all possible chart locations
  - Prioritize based on claim and encounter information but, given the impact and timing, pursue all possible charts

MMC 20/20 Approach to RADV Audits

- Initial provider contact is crucial
- Track all chart requests
- Follow up with providers promptly
  - Non-respondents
  - Partial respondents
  - Additional required information
- Also look for mitigating information
  - Insufficiently documented diagnoses
  - Lesser diagnoses within same hierarchy
  - Missing diagnoses
- Provide feedback to providers and groups to improve future performance and results
- Establish ongoing internal control process

Chart Review/Submission

- Having the right people to review the charts and determine if they are directly or indirectly submittable
- Request additional information from providers
- Follow-up with providers if the chart does not support their claims
- Track/record useful information to follow up after RADV
- Dispose of nothing until the RADV is completed
- Submit early and often
- Keep copies of everything you send to CMS vendor

Documentation Dispute Process

- Findings will contain CMS vendor identified "documentation dispute CMS-HCC discrepancies" (DDDs)
- Plan can also identify and propose additional DDDs
- Internal team members and/or vendor should be prepared to process results quickly
- Both dropped and demoted HCCs can be disputed
- HCCs identified for dispute will require specific detail that should be tracked during the initial audit process
  - Exact text in medical record verifying condition
  - Page and specific paragraph location in medical record
  - Original coversheet ID provided by CMS
  - Date of dates of service confirming condition
- Similar to initial RADV, any ICD-9 within the Audit HCC's hierarchy can be used to confirm a disputed condition

Documentation Dispute Process

- DDD process cannot be used to dispute interpretation of coding guidelines or introduce new documentation
- DDDs reviewed on individual basis and results reported back to plan
- DDDs not subject to further administrative review

New Appeals Process

- Appeal of CMS calculation of RADV payment error
- "To the extent that an MA organization believes that certain properties or attributes of payment error calculation were inaccurately reflected in the payment error, thus effecting the final payment error calculation, the MA organization may submit a written request for error calculation appeal to CMS"
- "MA organizations may not appeal medical record review errors"
- Cannot utilize the payment error calculation appeal as a method for submitting medical records for consideration (or even previously submitted medical records)
- Cannot utilize the appeal process to resolve signature or credential issues
- Cannot appeal CMS payment error calculation methodology

New Appeals Process

- Three step appeal process
  - Reconsideration
    - 30 days to file
    - CMS official not otherwise involved in determination
  - Hearing
    - 30 days to file
    - CMS Hearing Officer
    - No new evidence can be included in reconsideration request
  - CMS Administrator
    - 30 days to file
    - Has right to choose to review or not
- After this due process, have right to litigate

Defending Against Adverse Results/Extrapolation

- Extrapolation is new—CMS has not announced their methodology
- Key arguments:
  - One sided test—if CMS is to extrapolate, they must use over and under reporting
  - Happens in FFS—if CMS is to extrapolate, they must compare how results would compare to audit results in FFS
- Document under reporting by looking for unreported HCCs in same charts used during RADV audit
- Demonstrate that unsupported HCCs are based on claim information that is same as claim information used by CMS to develop HCC system and weights
- CMS has initially said that they would not consider these arguments, but they do have a solid basis and could provide a basis for arguing against extrapolation or reducing its impact
- Developing information is a by-product of audit support and is therefore low cost

Mock Audits – Objectives

Key Objective: organizational readiness/preparedness for any compliance audit

- Confirm ability to accurately collect/submit all applicable risk adjustment data
- Identify areas of external issues
- Identify areas of internal issues
- Identify what works, what doesn't, what to improve
- Gain experience/knowledge in timing, staffing
- Determine internal staffing and/or external resource/vendor

Mock Audits – Steps

- Organize & define specific audit team members
- Set realistic expectations
- Review available reports

  ex. Cumulative Plan Activity, Error Frequency
- Monitor/track provider data, w/considerations of provider training/relations
- Determine basis for financial statement accrual

Mock Audits - Sample

Use stratification for mock audit

- Provides better statistical reliability with a smaller sample
- Stratum should include:
  - HCCs supported by number of claims—(i.e. stratum would be HCC supported by one claim, two claims, etc.)
  - HCCs supported by hospital claims only
  - HCCs supported by PCP claim only
  - HCCs supported by SCP claim only
  - Other permutations
- Be sure to include all major providers in mock audits to gain sense of how their charts would fare in real audit
- Clearly indicate internal vs CMS audit, limit PHI data transmission